STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ILL6005623	A. BUILDING: _____ B. WING _____	C 06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYDIA HEALTHCARE	13901 SOUTH LYDIA ROBBINS, IL 60472

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #1693308/IL86274 Complaint #1693394/IL86364 Complaint #1693378/IL86350 Complaint #1693459/IL86438 Complaint #1693501/IL86481 Complaint #1693420/IL86392-No Findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing	S9999		

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S9999	Continued From page 2 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements Were Not Met As Evidenced By: Based on observation, interview and record review the facility failed to 1) follow facility policy regarding extreme high temperature and failed to identify, supervise or monitor a high risk resident in an outdoor area, for one of three sampled residents (R2) reviewed for supervision in a sample of eleven. This failure resulted in R2 being hospitalized in the Intensive Care for Heat Stroke and Acute Respiratory Failure. 2) Based on interview and record review the facility failed to report a serious incident for one of four residents (R2) reviewed for medical follow up in a sample of eleven. Findings include: The undated facility procedure "Extreme High Temperature Procedure" documents "Nursing Department Functions- High risk consumers should be identified and monitored closely during periods of extremely high temperatures. High risk consumers include those with heart, circulatory, or respiration problems, and those taking anticolinergics, diuretics, sedatives and hypnotics.	S9999		

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S9999	Continued From page 3 Checks consumers temperature and vital signs every 4-6 hours. Monitor all consumers frequently for symptoms of heat stroke and heat exhaustion. " On 6/29/2016 at 9:05 AM, E1 (Assistant Administrator) stated "We treat all residents as high risk for extreme heat. We do not have a list of residents who are high risk. No we don't take vitals every four hours. That must be an old policy." On 6/23/2016 at 10:00AM, the smoking patio had approximately 40 residents smoking or sitting outside. The patio area is open to direct sun with no shade (trees or canopy) of any kind to the area. There are nine benches for residents to sit on. The area is enclosed with a chain link fence. On 6/24/2016 at 8:40AM, E1 (Assistant Administrator) stated "The smoking area is approximately 500 square feet in diameter." On 6/23/2016 at 10:50AM, E10 (Operations Director) stated "It is not the facility policy to limit the amount of time a resident sits outside on the smoking patio." On 6/23/2016, E14 (Smoking Area Supervisor) stated " the smoking patio is open from 6:00AM to 9:30AM, 10:30AM to 3:30PM and 5:00PM to 9:30PM." The Smoke Room Supervision memo dated 1/5/2016 document on hot days water will be provided. Residents are allowed to sit in the smoking area during open smoking room hours. On 6/24/2016 at 8:40AM, E1 (Assistant Administrator) stated "There is no list of high risk residents for extreme temperatures. We consider all residents at the facility high risk for extreme temperatures. We put cold water on the smoking patio during extreme heat and encourage residents to drink the water while outside. The facility is alerted to extreme heat condition with a weather alert radio located in the front lobby."	S9999		

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S9999	Continued From page 4	S9999		

The web site "Local Conditions.com" documents the temperature on 6/11/2016 at 11:00AM through noon was 91 degrees Fahrenheit and the temperature from 1:00PM through 3:00PM was 93 degrees Fahrenheit with a humidity level of 49%.
R2's Physicians Order Sheet (POS), dated 6/7/2016, document a diagnosis of Asthma, Hypertension, Gastroesophagel Reflux Disease, and Schizophrenia. The POS also documents R2 receives a diuretic- Lasix 20 milligrams (mg) every morning and a Antiasthmatic - Symbocort AER 80-4.5 two puffs by mouth twice a day. The diuretic medication as well as the Asthma diagnosis places R2 on the high risk identifier per the facility Extreme High temperature Procedure."
R2's "Critical Incident Report" dated 6/11/2016 at 2:00PM documents "Consumer was observed sitting in a chair while outside. Consumer was unresponsive to verbal and tactile stimuli but breathing."
On 6/23/2016 at 2:05PM, E11(Peace Officer) stated " I found (R2) on the smoking patio sitting in a chair next to the fence across from the monitoring window at about 2:00PM, 611/2016. (R2) appeared to be slumped over with (R2's) head down and foaming at the mouth with head and body twitching movement noted. There were three other Peace Officers (E12, E14, E21) on the smoking patio when I arrived passing out cigarettes and walking around the patio making sure no altercations occurred. (R2) does not smoke, (R2) just likes to sit outside. (R2) is not able to be outside unless supervised due to having a "B" pass level. The only place the "B" level pass residents are allowed outside is the smoking patio, since the area is monitored by staff all the time it is open. I had last seen (R2) at about 12:30PM when I took (R2) to the unit for lunch."

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S9999	Continued From page 5	S9999		

On 6/23/2016 at 10:50AM, E12 (Peace Officer) also confirmed that R2 was drooling/foaming from the mouth slumped with head down sitting in a chair.
On 6/23/2016 at 9:35AM, E14 (Peace Officer, Smoking Supervisor) stated "There is always at least two staff on the smoking patios when it is open. We don't monitor the amount of time residents remain on the patio area. They come and go as they please. I was here the day that (R2) was sent to the hospital. I didn't see (R2) another peace officer did. I'm not sure who that peace officer was."
On 6/23/2016 at 2:00PM, E21 stated "I did not see (R2) I was passing cigarettes.
The "Floor Diner's Club" monitoring sheet dated 6/11/2016 documents R2 ate 100% of the lunch meal. Meal time for lunch is from 12:00PM to 1:00PM.
R2's Pass Level Safety Assessment dated 5/25/2016 documents R2 is on a level B pass.
The facility pass policy documents a level B pass as any resident deemed not appropriate for an independent pass level. Level B residents will be assigned supervised smoking on the facility smoking patio during designated times for the patio to be open.
On 6/23/2016 at 10:00AM, E17 (Security Supervisor) stated " When I heard the "Code Blue" called on 6/11/2016, I ran to the smoking patio. I saw (R2) sitting in the direct sun next to the fence. I assisted E11 to move (R2) to a shaded area near the building. We moved (R2) by lifting (R2) and the chair and moving it."
R2's progress noted dated 6/11/2016 documents "(R2) was noted unresponsive to verbal and tactile (sternum rub) stimuli but breathing. (R2) was outside in the smoking room sitting in a chair. Vital signs: blood/pressure-139/96, Pulse-156, Blood Glucose level-142, oxygen

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saturation-93% on room air. Call placed to 911. Physician notified. Ambulance arrived and transferred to the hospital." No other documentation for 6/11/2016 in R2's clinical record. No temperature documented at the facility on 6/11/2016.
R2's Ambulance report dated 6/11/2016 at 2:10PM documents " Upon arrival found patient (R2) on patio of the facility. The staff stated (R2) was found seizing completely unresponsive in a chair. Unknown how long patient was seizing. (R2) had tremor like activity. Post cardioversion (R2) returned to sinus rhythm immediately. Skin extremely dry to touch. Transferred care to the emergency room."
R2's Emergency Room report dated 6/11/2016 documents "(R2) presented with a 107.8 degree Fahrenheit temperature. (R2) placed on a cooler to lower core body temperature with ice packs placed directly on the skin. A Versed drip was placed. (R2) is intubated. (R2's) symptoms are consistent with Heat Stroke. Admitted to Intensive Care (ICU) for further aggressive care.
R2's hospital record documents an admission diagnosis of Heat Stroke, Acute Respiratory Failure, Acidosis, Dehydration, Anemia, and Febrile Seizures.
On 6/24/2016 at 1:45PM, Z1 (R2's Physician) stated " All I can say is if a resident is outside long enough in 93 degree weather, not coming out of the sun or drinking water they could get Heat Stroke. I would expect the facility to follow the facility extreme heat policy for supervision of residents."
On 6/29/2016 at 10:40AM, E1 (Assistant Administrator) stated "We only found out that (R2) was admitted to Intensive Care. We could not get the hospital to give any further information. We did not report this because we thought it was just a regular medical issue."

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S9999	Continued From page 7 The facility "Incident Reporting" policy documents "All critical incidents that results in serious injury or harm to the consumer shall then be reported to the state licensing agency. Those incidents excluded from this policy are those as a result of natural medical issues, excluding death." (A) 300.610a) 300.3240a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)	S9999		

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These requirements were not met as evidenced by:
Based on interview and record review the facility failed to prevent abuse and failed to report an incident of abuse to the Illinois Department of Public Health (IDPH). This applies to two (R3, R4) of nine residents reviewed for abuse in the sample of 11
The findings include:
On 6/28/16 at 1:57 PM, E19 (Mental Health Professional) stated on 6/2/16, E19 saw R3 pull R4 into the elevator. E19 stated E15 (Rehabilitation Services Associate/RSA) and E16 (RSA) saw the incident and were aware of what happened. E19 stated E15 and E16 laughed and one of them stated "He (R3) is our security." E19 stated she then reported the incident to E1 (Assistant Administrator).
The facility's Statement of Investigation Initial/Final report, dated 6/3/16, states on 6/3/16 R3 stated E15 and E16 told R3 to get R4 off the unit. R3 stated he followed E15 and E16's orders and initiated forceful tactics to remove R4 from the area because R4 would not listen. The Statement of Investigation Initial/Final report, states E15 and E16 were terminated effective 6/3/16, due to abuse/neglect of a consumer.
On 6/22/16 at 1:30 PM, E1 (Administrator) stated E15 and E16 were not terminated because they admitted to abuse, but because E16 and E15 did not report it to E1.
On 6/24/16 at 8:30 am, R3 stated he told R4 to leave the floor. R4 would not leave the floor, so E15 and E16 asked R3 to help.
On 6/23/16 at 11:30 AM, R4 was confused and unable to recall the incident.
The facility's undated Abuse Prevention Program Facility policy states abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishmant resulting in physical harm, pain, or

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S9999	Continued From page 9 mental anguish...Employees are required to report any occurrences of potential mistreatment they observe." (B)	S9999		

Imposed Plan of Correction

Facility Name: Lydia Healthcare

Survey Date: June 29, 2016

Survey Type: Complaint Survey

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated there under. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Attachment B
Imposed Plan of Correction

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

This will be accomplished by the following:

A) A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse, and neglect, including the policy and procedure for extreme weather conditions. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

1). Recognition of situations that could be interpreted as abusive or neglectful.

2). Appropriate reporting procedures for staff.

3). Appropriate and thorough investigations of alleged abuse or neglect.

4). The facility's responsibilities to prevent further potential abuse or neglect.

5). All care plans will be reviewed and revised as needed for residents at high risk or compromised for temperature extremes.

6).Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plans.

7). Develop and implement a system to ensure accurate monitoring and safety of residents when climate temperatures are extreme.

B). The facility will conduct MANDATORY in-services for all staff within 10 days that addresses, at a minimum, the following:

1). Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.

2). All staff will be informed of their specific responsibilities and accountability for the care provided to residents.

3). Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.

C). The following actions shall be taken to prevent re-occurance:

1). The above In-Service Education will be reviewed with all staff on a regular basis.

2). Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations (reporting and follow-up) are followed.

3). Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned.

4). An audit shall be conducted and documented by the facility's nurse consultant monthly for three months to ensure that, successful completion of the above policies.

The Administrator and Director of Nursing will monitor to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Correction.